MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2002

Aetna Health Inc.
6430 S. Fiddler's Green Circle
Englewood, Colorado 80111

NAIC Group Code 0001
NAIC Company Code 95256

EXAMINATION PERFORMED BY
DIVISION OF INSURANCE STAFF
COLORADO DEPARTMENT OF REGULATORY AGENCIES
STATE OF COLORADO

Aetna Health Inc.
6430 S. Fiddler's Green Circle
Englewood, CO 80111

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2002

Examination Performed by
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State Market Conduct Examiners

March 12, 2004

The Honorable Doug Dean
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of Aetna Health Inc. (the Company) was conducted pursuant to Section 10-16-416, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine health maintenance organizations. We examined the Company's records at its Denver office located at 6430 S. Fiddler's Green Circle, Englewood, Colorado 80111 and at the Colorado Division of Insurance offices at 1560 Broadway, Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2002, through December 31, 2002.

The following market conduct examiners respectfully submit the results of the examination.

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MARKET CONDUCT EXAMINATION REPORT OF AETNA HEALTH INC.

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COMPANY PROFILE

The Company provided the following history:

June 19, 1995	The HMO was first incorporated as Frontier Community of Health Plans, Inc.
April 9, 1997	The HMO adopted from Aetna U. S. Healthcare of Colorado, Inc. (which was dissolved on March 28, 1997) the name Aetna U. S. Healthcare of Colorado, Inc.
December 15, 1998	The name of the HMO was changed to Aetna U. S. Healthcare Inc.
May 1, 2002	The current name of Aetna Health Inc., was subsequently adopted.

Currently the HMO is licensed to do business in the State of Colorado.

The HMO Service area includes the following 14 Colorado counties:

Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Elbert, El Paso, Fremont, Jefferson, Larimer, Mesa, Pueblo, and Teller.

Plan of Operation:

Aetna Health Inc. provides a prescribed range of healthcare services to an enrolled population through contracted providers. These services include medical, hospital, dental and vision care that is primarily offered to large employers for the benefit of employees and their dependents.

The Health Maintenance Organization (HMO) is a pre-paid medical plan that uses a network of participating providers. Members select a primary care physician (PCP) participating in the Company's network. The PCP provides routine and preventative care and helps coordinate the member's total health care. The PCP refers members to participating specialists or facilities for medically necessary specialty care. Services not provided or referred by the PCP are not covered except for emergency, urgently needed care or direct access benefits unless approved by the HMO in advance of receiving services.

US Access is a three-tiered HMO-based product, which allows members, to access care in three ways: In-network referred (lowest copay), In-network self-referred (higher copay/possible coinsurance), or out-of-network (subject to deductible and coinsurance). US Access was designed to move customers and members into a managed care product by providing the flexibility to self refer to network specialists and network facilities (within the HMO network) while requiring only slightly higher cost sharing from the member. US Access should be targeted to customers who were reluctant in the past to offer a managed care product, or who want the most "access" options for their employees.

QPOS was designed as a "stepping stone" between HMO and PPO. It is a two-tiered product that allows members to access care in one of two ways: Referred in-network (subject to copay) or Self-referred, in-or out-of-network (subject to deductible and coinsurance). Members have lower out of pocket costs when they use the HMO tier of the plan and follow the PCP referral process. Member cost sharing increases if members decide to self refer in-or out-of-network.

Aetna Health has dedicated sales and service personnel responsible for the selling and servicing of local businesses as well as those customers who operate on a national basis. The sales department works with the broker and consultant communities to obtain new business and retain the existing customer base. A new sales model and organizational structure has recently been implemented. Two business segments have been developed which include: 1) National Accounts and 2) Select and Key Accounts.

Service Area

The Company is licensed to provide services in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Elbert, El Paso, Fremont, Jefferson, Larimer, Mesa, Pueblo, and Teller counties in Colorado.

Large Group Enrollment As of 12-31-02**:	51,358
Large Group Written Premium as of 12-31-02**:	$136,158,350
Market Share (all Colorado HMO's):	5.26%

** As provided by the Company.

PURPOSE AND SCOPE OF EXAMINATION

State market conduct examiners with the Colorado Division of Insurance (DOI), in accordance with Colorado Insurance Law, Sections 10-1-201, 10-1-203, 10-1-204 and specifically 10-16-416, C.R.S., that empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Aetna Health Inc. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to Health Maintenance Organizations (HMO's). Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The limited market conduct examination covered the period from January 1, 2002, through December 31, 2002.

The examination included review of the following:

Company Operations/Management;
Contract Forms;
Rating;
Applications/Renewals;
Cancellations/Non-renewals/Declinations;
Claims Handling; and
Utilization Review.

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties, were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to large group health insurance reform laws as they pertained to health maintenance organizations. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any health maintenance organization.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and Colorado regulations as they pertain to health maintenance organizations. For this examination, special emphasis was given to Health Maintenance Organization reform and the laws and regulations as shown in Exhibit 1.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1101-10-3-1104	Unfair Competition - Deceptive Practices
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-401-10-16-427	Health Maintenance Organizations
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Regulation 1-1-4	Maintenance of Offices in this State
Regulation 1-1-7	Market Conduct Record Retention
Regulation 1-1-8	Penalties and Timelines Concerning Division Inquires and Document Requests
Regulation 4-2-5	Hospital Definition
Regulation 4-2-11	Individual and Group Health Insurance Rate Filings
Regulation 4-2-15	Required Provisions in Carrier Contracts with Providers and Intermediaries Negotiating on Behalf of Providers
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Regulation 4-6-9	Conversion Coverage
Regulation 4-7-1	Health Maintenance Organizations
Regulation 4-7-2	Health Maintenance Organization Benefit Contracts and Services in Colorado

Company Operations/Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company was the subject of a previous market conduct exam in 1998 and 1999 that covered the period January 1, 1998 through December 31, 1998. The Company also underwent a financial audit by the Colorado Division of Insurance in 1999 that covered the period of June 21, 1995 through December 31, 1998.

Contract Forms

The examiners reviewed the following forms:

- The Company Co-payment Schedules, Evidences of Coverage and Schedule of Benefits;
- The Company's most commonly sold HMO group contracts marketed to large groups;
- The Company's HMO conversion contracts, application form, definitions, eligibility, and termination provisions; and
- The Company's group and employee HMO applications/enrollment forms and supporting documents.

These plans were issued and/or certified with the Colorado Division of Insurance (DOI) between January 1, 2002 and December 31, 2002.

Rating

The examiners reviewed the premium rates charged in the samples of the files selected in the Underwriting new business applications section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period as well as for compliance with the appropriate statutes and regulations.

Applications/Renewals

For the period January 1, 2002 through December 31, 2002, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- The entire population of four (4) large group new business application files; and
- Fifty (50) renewed large group files.

Cancellations/Non-Renewals/Declinations

For the period January 1, 2002 through December 31, 2002, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- Fifty (50) large group cancellation/non-renewal files; and
- Fifty (50) declined large group files.

Claims

Utilizing ACL™ software, the examiners selected samples of 100 paid and 100 denied large group HMO claims that were received during the period of January 1, 2002 through December 31, 2002. These claims were reviewed for the Company's overall claims handling practices and to determine accuracy of processing. It was determined that a sample size of 100 claims was appropriate in both of the above samples.

In order to determine the Company's compliance with Colorado's prompt payment of claims law, the examiners also reviewed a random sample of 100 claims not paid within the required timeframes.

In addition, the examiners identified 122 claims out of a population of 476,764 denied and paid large group claims that were not paid, or settled within ninety (90) days after receipt. The Company was unable to provide the examiners with the original received date of many claims due to its method of renumbering (claim copying) claims upon reopening them for reprocessing and thus giving them a new received date. Since original received dates could only be found by opening each claim individually, the examiners were unable to pull an accurate population of claims for timeliness studies. Therefore the population of 122 appears to be less than the actual number of claims that exceeded ninety (90) days. These claims were reviewed to determine if they had been delayed due to fraud, and if not, if interest and penalties had been paid. The Company does not accurately track original received dates on many of its claims and therefore the 122 claims identified above is probably only a fraction of the total claims processed over ninety (90) days.

Utilization Review

The examiners reviewed the Company's utilization management program including policies and procedures. The examiners also reviewed the entire population of forty-six (46) first level appeal files, the entire population of ten (10) second level appeal files, and the entire population of one (1) external review file. Reconsiderations were not reviewed due to the fact that the Company does not track them.

In addition, the examiners selected a sample of fifty (50) utilization review (UR) denial decision files from total populations of 453. However, this sample was reduced to forty-seven (47) due to the fact that three (3) of the files were withdrawn from consideration by either the provider or member prior to being processed. The examiners also selected a sample of fifty (50) utilization review (UR) certification decisions from a total population of 2,479. These sample files were reviewed for the Company's overall UR handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty-five (25) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

Operations/Management: The examiners identified two (2) areas of concern in their review of the Company's operations/management.

1. Failure, in some instances, to provide a complete response to examiners inquiries regarding utilization review.

2. Failure, in some instances, to maintain records required for market conduct purposes. *(This was prior issue E23 in the findings of the 2000 final examination report.)*

Contract Forms: The examiners identified six (6) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and any riders).

1. Failure to include the correct time frame for processing expedited appeals.

2. Failure to provide a complete and accurate description of the required Hospice Care benefits.

3. Failure to provide for continued coverage of a condition after a member has refused a recommended procedure or treatment.

4. Failure to include allowable amendments to large group plans only in the instances permitted by law. *(This was prior issue E19 in the findings of the 2000 final examination report.)*

5. Failure to include coverage for feeding appliances for newborns with cleft lip or cleft palate or both.

6. Failure to provide mandated coverage of therapies for treatment of congenital defects and birth abnormalities for covered children under five (5) years old.

Rating: There were no issues cited in this area of the exam.

Applications/Renewals: There were no issues cited in this area of the exam.

Cancellations/Non-Renewals/Declinations: There was one (1) area of concern identified during the review of the large group cancellation/non-renewal/declination files.

1. Failure, in some instances, to refund unearned premium in a prompt manner or to refund premium at all when it is due.

Claims: The examiners identified four (4) areas of concern in their review of the claims handling practices of the Company.

1. Failure, in some instances, to pay eligible charges or to request the additional information needed to properly adjudicate claims. *(This was prior issue J2 in the findings of the 2000 final examination report.)*

2. Failure, in some instances, to process claims accurately. *(This was prior issue J1 in the findings of the 2000 final examination report.)*

3. Failure, in some instances, to pay, deny, or settle clean claims within the time frames required by law.

4. Failure, in some instances, to pay interest and or penalty on claims within the time frames required by law.

The examiners recommend that the Company review its claim processing procedures and quality controls to ensure that claims are processed accurately and within the required time frames. The Company also needs to revise it procedures regarding claim copies to ensure that the original received date is used in all instances where a claim is reopened except if new information from a provider or member is received. Additional training of claims personnel should occur as needed. The additional benefits due on all underpaid claims resulting from the Company's incorrect received date tracking should be paid in a timely manner.

Utilization Review: The examiners identified twelve (12) areas of concern in their review of the Company's Utilization Review procedures.

1. Failure, in some instances, to include the correct approval requirements in utilization review approval letters.

2. Failure, in some instances, to include all the required elements on utilization review denial notification letters.

3. Failure, in some instances, to make prospective utilization review determinations within the time frame allowed by Colorado insurance law.

4. Failure, in some instances, to provide telephone and/or written notification of adverse prospective utilization review denials within the time frames required by Colorado insurance law.

5. Failure, in some instances, to provide telephone notice of utilization review approvals within the time frame required by Colorado insurance law.

6. Failure, in some instances, to have first level appeals reviewed by physicians.

7. Failure, in some instances, to provide written notification of first level appeal decisions within the timeframes required by law. *(This was prior issue K1 in the findings of the 2000 final examination report.)*

8. Failure to include all required elements in written notification letters sent to members and providers. *(This was prior issue K3 in the findings of the 2000 final examination report.)*

9. Failure, in some instances, to provide notification of second level review meetings within the timeframe required and failure to conduct the review meetings within the timeframe required.

10. Failure, in some instances, to include health care professionals with appropriate expertise in the second level review panels.

11. Failure, in some instances, to provide prior notification to members of the presence of Company attorneys at second level review meetings.

12. Failure, in some instances, to include all the required elements in written notifications of second level appeal determinations.

The examiners recommend that the Company review its utilization review procedures to ensure that determinations are rendered within the required time periods, and that appropriate individuals were involved. The Company also needs to ensure that all required information is provided in the notifications and that they are provided within the required time periods.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance. Results of previous Market Conduct Exams are available on the Colorado Division of Insurance website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

AETNA HEALTH INC.

COMPANY OPERATIONS/MANAGEMENT FINDINGS

Issue A1: Failure, in some instances, to provide a complete response to examiners inquiries.

Regulation 1-1-8, amended effective June 2, 2003, Market Conduct Record Retention, promulgated pursuant to Section 10-1-109, 10-2-104, 10-3-109(3) and 10-16-109, C.R.S., states:

> 5. Rules
>
> A. Unless another time period is specified by the Division is writing, every person shall provide a *complete response* [emphasis added] to Examination Request/Comment Forms within ten (10) calendar days from the date on the form.

It appears that the Company is not in compliance with Colorado insurance law in that in failed to provide a complete response to examiner inquires in some instances as noted below:

- The utilization review procedures were provided, as requested, at the start of the exam, October 21, 2003. However, during the review of the appeal files, the examiners questioned the Company representative on some information in the files and as part of the Company's response, it was determined that not all of the procedures had been provided initially. Additional procedures were requested and supplied in February 2004.

- An appeal log and the appeal files were also provided at the start of the exam. However, after reviewing the utilization review denial files the examiners noted that there were appeals for files that did not have corresponding utilization review denial files. After the examiners questioned the Company about this, the examiners were informed that some appeals for small groups, for members outside of Colorado, and for received dates not within the examination period had been included in the original files. Also, it was discovered that the Company had missed giving the examiners other applicable appeal files. These files were received in January 2004.

- A list of utilization review approvals and denials was obtained at the beginning of the exam. Upon sampling and review of the files, the examiners noted some conflicting information and evidence that the list of denials had not been complete. Upon bringing this to their attention, the Company agreed that the list of denials was incomplete and also explained that the list of approvals was incomplete as well. New file lists were provided and the examiners resampled and completed a new review.

- During the review of the new sample of utilization review denials, the examiners discovered that two (2) additional appeal files were missing. These files were requested by examiners on February 11, 2004 and supplied on February 18, 2004.

- In reviewing the records of the Colorado division of insurance, it was determined that there was one external appeal file that had not been provided or listed in the information originally supplied to examiners. This file was later provided after being specifically requested.

- Upon review of the contents of the files, the examiners also noted that it appeared the appeal files were missing relevant documentation. The Company reviewed the files and agreed some documents were missing. These additional documents were provided on January 30, 2004.

Recommendation No.1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 1-1-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has modified its procedures to ensure that complete responses to examiners inquiries regarding utilization review are provided as required by Colorado insurance law.

Issue A2: Failure, in some instances, to maintain records required for market conduct purposes.
(This was prior issue E23 in the findings of the 2000 final examination report.)

Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of Section 10-1-109, C.R.S., states:

B. RECORDS REQUIRED FOR MARKET CONDUCT PURPOSES

1. Every insurer/carrier or related entity licensed to do business in this state shall maintain its books, records, documents and other business records so that the insurer's/carrier's or related entity's claims, rating, underwriting, marketing, complaint, and producer licensing records are readily available to the commissioner. Unless otherwise stated within this regulation, records shall be maintained for the current calendar year plus two calendar years.

2. A policy record shall be maintained for each policy issued in this state. Policy records shall be maintained for the current policy term, plus two calendar years, unless otherwise contractually required to be retained for a longer period. Provided, however, documents from policy records no longer required to be maintained under this regulation, which are used to rate or underwrite a current policy, must be maintained in the current policy records. Policy records shall be maintained so as to show clearly the policy term, basis for rating, and, if terminated, return premium amounts, if any. Policy records need not be segregated from the policy records of other states so long as they are readily available to the commissioner as required under this rule. A separate copy need not be maintained in the individual policy records, provided that any data relating to that policy can be retrieved. Policy records shall include:

   a. The application for each policy, if any;

   b. Declaration pages, endorsements, riders, termination notices, guidelines or manuals associated with or used for the rating or underwriting of the policy. Binder(s) shall be retained if a policy was not issued; and

   c. *Other information necessary for reconstruction of the rating and underwriting of the policy.* [Emphasis added.]

3. *Claim files shall be maintained so as to show clearly the inception, handling and disposition of each claim.* [Emphasis added.] A claim file shall be retained for the calendar year in which it is closed plus the next two calendar years.

Records required to be retained by this regulation may be maintained in paper, photograph, microprocess, magnetic, mechanical or electronic media, or by any process which accurately reproduces or forms a durable medium for the reproduction of a record. A company shall be in compliance with this section if it can produce the

> data which was contained on the original document, if there was a paper document, in a form which accurately represents a record of communications between the insured and the company or accurately reflects a transaction or event.
>
> Records required to be retained by this regulation shall be readily available upon request by the commissioner or a designee. Failure to produce and provide a record within a reasonable time frame shall be deemed a violation of this regulation, unless the insurer or related entity can demonstrate that there is a reasonable justification for that delay.

It appears that the Company is not in compliance with Colorado insurance law in that in some cases it did not maintain the records required for market conduct purposes to be able to reconstruct the rating, and/or underwriting of a particular policy nor were the examiners able to determine the inception, handling and disposition of each claim.

Specifically, the termination and renewal records provided to the examiners did not contain sufficient documentation for the examiners to be able to verify and/or calculate the following:

- The actual number of eligible employees in the group at renewal;
- That the Company was following its eligibility and enrollment guidelines for large group renewals;
- That renewal policies were accurately rated; and
- That the termination and renewal files provided for examiner review were issued and qualified as large employer groups and were therefore within the scope of the examination.

The examiners note that a screen in the GEBAR system is populated with the number of eligible employees, however, there is no additional data in the electronic or paper file to substantiate this number. Specifically, the files did not contain an employer/company prepared census of eligible employees or listing of enrolled employees. The examiners made specific requests for additional supporting documentation relating to the number of eligible employees, number of enrolled employees and other supporting documentation and the Company failed to provide this information.

In addition, the following discrepancies were noted in the claim records:

- The Company was unable to provide the examiners with a list of claims that distinguished between those received in paper form and those received electronically. Although the Company was able to indicate the receive type on some of the claims, many of the claim types indicated on the file list provided by the Company at the start of the examination were incorrect and had to be changed during the examiners review. This prevented the examiners from being able to perform accurate claims payment timeliness samples.
- The Company was unable to provide the examiners with the original received date of many claims due to its method of renumbering (claim copying) claims upon reopening them for reprocessing. The only time claims should be given a new received date is if new/additional information is received regarding the claim. Since original received dates could only be

found by opening each claim individually, the examiners were unable to pull an accurate population of claims for timeliness studies.

- The Company did not properly identify many of the utilization review appeals that occurred during the exam period. Upon review of the files provided, the examiners determined that some second level appeals were incorrectly labeled as first level only and some appeals were labeled first level but were not received during the exam period. Also, the second level appeal list provided by the Company included a member appeal for which no file could be found. Upon notification of this, the Company stated that there was a mistake on the list provided and there was no second level appeal for the member listed during the exam period.

- The Company does not accurately track dates when written notification letters are sent in all instances for utilization review appeals. The examiners noted that many written notification letters contained dates that occurred days, weeks, or months before the date of the notes in their note tracking system ("etums"), indicating that a decision had been reached and a written notification letter needed to be mailed.

- The Company's utilization review second level appeal files were incomplete in that in some instances, the examiners were unable to determine who participated on the panel during the hearing or if an attorney for the Company was present during the hearing, and if so, if appropriate notice had been provided to the member before hand.

Recommendation No.2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 1-1-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that records required for market conduct purposes are maintained as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 1998 through December 31, 1998, the Company was cited for failure to maintain records. The violation resulted in Recommendations #32 and #45, that the Company establish procedures to ensure that records are maintained in accordance with law. Failure to comply with the previous recommendations and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

UNDERWRITING
CONTRACT FORM
FINDINGS

Issue E1: Failure to include the correct time frame for processing expedited appeals.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states:

> **Section 8. Appeals of Adverse Determinations**
>
> II. Expedited Appeals
>
> A health carrier shall establish written procedures for the expedited review of an adverse determination involving a situation where the time frame of the standard review procedures set forth in Section 8.I.A or B would seriously jeopardize the life or health of the covered person, would jeopardize the covered person's ability to regain maximum function, or, for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. Such procedures shall be consistent with the provisions of Section 6.G. of this regulation concerning claims for emergency services. An expedited appeal shall be available to, and may be initiated by, the covered person or the provider acting on behalf of the covered person.
>
> D. In an expedited review, a health carrier shall make a decision and notify the covered person or the provider acting on behalf of the covered person's behalf as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the review is commenced. If the expedited review is a concurrent review determination, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

It appears that the Company is not in compliance with Colorado insurance law in that its certificate of coverage form provides for ninety-six (96) hours to make a determination in urgent cases. Colorado law allows no more than seventy-two (72) hours to make an expedited appeal decision. Although the Company's form does list the seventy-two (72) hour time frame, in one place, the expedited appeal section also provides for an allowance of ninety-six (96) hours for urgent appeals. The Company's Certificate of Coverage form states:

> **UTILIZATION REVIEW PROCEDURE**
>
> G. Expedited Appeals.
>
> 5. In an expedited review, HMO shall make a decision and notify the Member or the Provider acting on behalf of the Member as expeditiously as the Member's condition requires, but in no event more than 72 hours after the review is commenced. If the expedited review is a Concurrent Review determination, the service shall be continued without liability to the Member until the Member has been notified of the determination.
>
> 8. *In the event the issue is of an urgent nature, an HMO Medical Director shall review the matter and make a determination within 96 hours of receipt.* [Emphasis added.]

The examiners do note that the Company amended its certificate of coverage effective October15, 2002, and removed all references to the ninety-six (96) hour determination time frame.

Form	Dated
HMO/CO COC-6	06/01

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its certificate of coverage forms to reflect the correct time frame for processing expedited appeals as required by Colorado insurance law.

Issue E2: Failure to provide a complete and accurate description of the required Hospice Care benefits.

Regulation 4-2-8, amended effective February 1, 2001, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of Sections 10-1-109 and 10-16-104(8)(d), C.R.S., states:

> **Section 5. Requirements for Hospice Care**
>
> C. Benefits for Hospice Care Services.
>
> (3) *The policy offering shall include the following benefits*, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:
>
> (i) *Transportation*; [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its Certificate of Coverage form does not provide coverage for transportation services for hospice care patients. Colorado law requires coverage for transportation services as part of the hospice benefit. The Company's form states:

> [N]. Hospice Benefits.
>
> Hospice Care services for a terminally ill Member are covered when pre-authorized by HMO. Services may include home and Hospital visits by nurses and social workers; Physician; certified nurses aid; pastoral counseling; trained volunteer; bereavement counseling; pain management and symptom control; instruction and supervision of a family Member; inpatient care; counseling and emotional support; and other home health benefits listed in the Home Health Benefits section of this Certificate.
>
> *Coverage is not provided for* funeral arrangements, financial or legal counseling. Homemaker or caretaker services, and any service not solely related to the care of the Member, including but not limited to, sitter or companion services for the Member or other Members of the family, *transportation*, house cleaning, and maintenance of the house are not covered. [Emphases added.]

Form	Dated
HMO/CO COC-6	06/01

Recommendation No. 4:

Within thirty (30) days the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all certificate of coverage forms to include a correct and complete description of the required hospice care benefit to ensure compliance with Colorado insurance law.

Issue E3: Failure to provide for continued coverage of a condition after a member has refused a recommended procedure or treatment.

Section 10-16-102, C.R.S., Definitions, states:

> (5) "Basic health care services" means health care services that an enrolled population of a health maintenance organization organized pursuant to the provisions of part 4 of this article might reasonably require in order to maintain good health, including as a minimum emergency care, inpatient and outpatient hospital services, physician services, outpatient medical services, and laboratory and X-ray services.

Section 10-16-402, C.R.S., Issuance of certificate of authority – denial, states:

> (2)(c) *The health maintenance organization will effectively provide or arrange for the provision of basic health care services* [emphasis added] on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments, deductibles, and payments for out-of-network services received pursuant to section 10-16-704(2).

It appears that the Company is not in compliance with Colorado insurance law in that its certificate of coverage form indicates that neither the HMO or a Participating Provider will have further responsibility to provide any of the benefits under the certificate for certain health services otherwise available, including services for conditions resulting from or related to another condition, if a member refuses to comply with the recommended treatment of a Participating Provider. Under Colorado insurance law, the Company cannot refuse to provide necessary treatments that are otherwise covered benefits, solely because a member has refused a recommended procedure. The Company's Certificate of Coverage states:

> C. Refusal of Treatment. A Member may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a Participating Provider. If the Participating Provider (after a second Participating Provider's opinion, if requested by Member) believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to follow the recommended treatment or procedure, neither the Participating Provider, nor HMO, will have further responsibility to provide any of the benefits available under this Certificate for treatment of such condition or its consequences or related conditions. HMO will provide written notice to Member of a decision not to provide further benefits for a particular condition. This decision is subject to the [Grievance Procedure] in this Certificate. Coverage for treatment of the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

Form	Dated
HMO/CO COC-6	06/01

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-402, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to provide for continued coverage of a condition regardless of whether a member has refused a recommended procedure or treatment, to ensure compliance with Colorado insurance law.

Issue E4: Failure to include allowable amendments to large group plans only in the instances permitted by law.

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states:

> 5. A large group health benefit plan carrier may modify a large group health benefit plan at renewal pursuant to 10-16-214(3)(a)(IV) if all those large groups covered by the same plan are uniformly modified.

It appears that the Company's forms are not in compliance with the requirements of Colorado insurance law in that its Group Agreement allows for amendment upon the Company's written notice to the contract holder. Colorado law requires group health benefit plans to be guaranteed renewable except that a carrier may modify a large group plan if the amendment applies to all large groups covered by the same plan, and only if it is effective upon renewal. The Company's Group Agreement form states:

9.4 Amendments. This Group Agreement may be amended as follows:

- This Group Agreement shall be deemed to be automatically amended to conform with all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over Us;
- *By Us upon [30-120] days written notice to Contract Holder*. [Emphases added.]

The Parties agree that an amendment does not require the consent of any employee, Member or other person. Except for automatic amendments to comply with law, all amendments to this Group Agreement must be approved and executed by Us. No other individual has the authority to modify this Group Agreement; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **Us** by making any other commitment or representation or by giving or receiving any information.

Form	Dated
HMO/CO GA-5	11/01

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-201.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its group agreement to include only allowable provisions for amendment of a group contract in compliance with Colorado insurance law.

Issue E5: Failure to include coverage for feeding appliances for newborns with cleft lip or cleft palate or both.

Section 10-16-104, C.R.S. Mandatory coverage provisions, states:

(1) Newborn children.

(c) (II) (A) With regard to newborn children born with cleft lip or cleft palate or both, there shall be no age limit on benefits for such conditions, and care and treatment shall include to the extent medically necessary: Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and *feeding appliances* [emphasis added]; medically necessary orthodontic treatment; medically necessary prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment.

It appears that the Company is not in compliance with Colorado insurance law in that its certificate of coverage form does not provide coverage for feeding appliances for newborn children born with cleft lip or cleft palate, or both. Colorado law requires coverage of feeding appliances for these newborns. The Company's form states:

[R]**. Cleft Lip or Cleft Palate Benefits.**

Benefits shall be provided for newborn children born with cleft lip, or cleft palate, or both when Medically Necessary and upon prior Referral by the Member's PCP. Care and treatment shall include:

1. oral and facial surgery, surgical management, and follow-up care by plastic surgeons;
2. prosthetic treatment such as obturators, speech appliances;
3. orthodontic treatment;
4. prosthodontic treatment;
5. habilitative speech therapy;
6. otolaryngology treatment; and
7. audiological assessments and treatment.
8. Rehabilitation therapies up to five years of age as follows:

- Up to a maximum of 20 therapy visits per Contract Year for physical therapy;
- Up to a maximum of 20 therapy visits per Contract Year for occupational therapy; and
- Up to a maximum of 20 therapy visits per Contract Year for speech therapy.

Therapy visits shall be distributed as Medically Necessary without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

Form	Dated
HMO/CO COC-6	06/01

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its certificate of coverage form to include coverage for feeding appliances for newborn children with cleft lip or cleft palate as required by Colorado insurance law.

Issue E6: Failure to provide mandated coverage of therapies for treatment of congenital defects and birth abnormalities for covered children under five (5) years old.

Section 10-16-104, C.R.S., Mandatory Coverage Provisions, states:

> 1.7 **Therapies for congenital defects and birth abnormalities.** (a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children up to five years of age.
>
> (b) The level of benefits required in paragraph (a) of this subsection (1.7) shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy. *Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity*. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its certificate of coverage form allows for coverage of certain therapies only if they are being provided for non-chronic conditions. This is more restrictive than Colorado law that requires coverage of physical, occupational, and speech therapy for children under five (5) years old with congenital defects and birth abnormalities, without regard to whether the condition is chronic or acute. The Company's Certificate of Coverage states:

> [L]. Outpatient Rehabilitation Benefits.
>
> The following benefits are covered by Participating Providers upon Referral issued by the Member's PCP and pre-authorization by HMO.
>
> 4. Physical therapy is covered for *non-chronic* conditions and acute illnesses and injuries. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.
>
> 5. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for *non-chronic* conditions and acute illnesses. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.
>
> 6. Speech therapy is covered for *non-chronic* conditions and acute illnesses and injuries and is subject to the limits, if any, shown on the Schedule of Benefits. Services rendered for the treatment of delays in speech development, unless resulting from disease, injury, or congenital defects, are not covered. [Emphases added.]

In addition, the Company's schedule of benefits form does not appear to be in compliance with Colorado insurance law in that its requires the mandated therapies to be provided during a consecutive sixty (60) day period. This is more restrictive than Colorado law that requires therapies for congenital defects and birth abnormalities to be distributed as medically appropriate throughout the year of the policy. The Company's Schedule of Benefits states:

Benefit	**Copayment**
[Outpatient Physical Therapy *[Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment]* [Emphasis added.] [[20-90] visits [per [consecutive] period per incident of illness or injury beginning with the first day of treatment] per [calendar year; **Contract Year**]]]	**[[$[0-50] [after Deductible] per visit] [[10-30]% (of the contracted rate) [after Deductible] per visit]]**
[Outpatient Occupational Therapy *[Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment]* [Emphasis added.] [[20-90] visits [per [consecutive] period per incident of illness or injury beginning with the first day of treatment] per [calendar year; **Contract Year**]]]	**[[$[0-50] [after Deductible] per visit] [[10-30]% (of the contracted rate) [after Deductible] per visit]]**
[Outpatient Speech Therapy [*Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment]* [Emphasis added.] [[20-90] visits [per [consecutive] period per incident of illness or injury beginning with the first day of treatment] per [calendar year; **Contract Year**]]]	**[[$[0-50] [after Deductible] per visit] [[10-30]% (of the contracted rate) [after Deductible] per visit]]**

Form	Dated
HMO/CO COC-6	06/01
HMO/CO SB-5	11/01

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its certificate of coverage and schedule of benefits forms to allow for coverage of therapies for chronic conditions for children under five (5) years of age as required by Colorado insurance law.

UNDERWRITING
CANCELLATIONS/NON-RENEWALS/DECLINATIONS
FINDINGS

Issue H1: Failure, in some instances, to refund unearned premium in a prompt manner.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (m) Failure to make promptly a full refund or credit of all unearned premiums to the person entitled thereto upon termination of insurance coverage;…

CANCELLED LARGE GROUP FILE SAMPLE – Refund of Premium

Population	Sample Size	Number of Exceptions	Percentage to Sample
129	50	8	16%

The examiners reviewed a randomly selected sample of fifty (50) files from a summarized population of 129 Cancellation files from the examination period of January 1, 2002 to December 31, 2002. It appears that in thirteen (13) instances the Company was not in compliance with Colorado insurance law in that:

1. In eight (8) cases, the return of unearned premium was not refunded to the sponsoring employer group in a prompt manner.

Although a specific time period for providing a refund to group policyholders is not specified in Colorado insurance laws, the Division of Insurance has traditionally applied a standard of thirty (30) days from the time a refund was due to determine whether a refund was provided promptly.

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that refunds required as a result of a cancellation of group coverage are provided promptly as required by Colorado insurance law.

CLAIMS
FINDINGS

Issue J1: Failure, in some instances, to pay eligible charges or to request the additional information needed to properly adjudicate the claims.

Section 10-3-1104(1)(f)(II), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of the section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process.

DENIED CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
66,791	100	8	8%

From a population of 66,791 denied claims received from January 1, 2002, through December 31, 2002, a randomly selected sample of 100 denied claims was reviewed.

It appears that the Company is not in compliance with Colorado insurance law in that at the time the claims were denied, the Company either:

- was in possession of the information it needed to properly adjudicate the claims; or
- it failed to request required additional information before denying the claim.

It appears that this resulted in unfair and inconsistent treatment of members as follows:

- Two (2) claims (Comments J7, and J13) involved claims that were denied due to a lack of authorization or referral on file;
- Two (2) claims (Comments J2 and J6) were incorrectly denied as duplicates;
- One (1) claim (Comment J11) was incorrectly denied for no PCP;
- One (1) claim (Comment J9) was incorrectly denied for missing information;
- One (1) claim (Comment J17 was incorrectly denied as service incidental; and
- One (1) claim (Comment J18) was incorrectly denied as being included in a global fee.

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104 and 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed and modified its quality controls to ensure that its processing staff is properly trained to make appropriate decisions and thus avoid denying eligible claims to assure compliance with Colorado insurance law.

Issue J2: Failure, in some instances, to process claims accurately.

Section 10-3-1104(1), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

(f) Unfair discrimination:

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; …

HMO PAID CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
409,973	100	6	6%

A random sample of HMO paid claims was selected and reviewed for accuracy of processing during the examination period of January 1, 2002 through December 31, 2002. It appears that the Company is not in compliance with Colorado insurance law in that six (6) claims do not appear to have been processed correctly based on a review of the information provided. The errors included incorrect application of copays, coinsurance, and deductibles.

Recommendation No. 11:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed and modified its claims processing quality controls to ensure that all claims are investigated properly to determine the proper allocation of benefits as required by Colorado insurance law.

Issue J3: Failure, in some instances, to pay, deny, or settle claims within the time frames required by law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the carrier's standard claim form with all required fields completed with correct and complete information in accordance with the carrier's published filing requirements. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.* [Emphasis added.]
>
> (c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphasis added.]

CLEAN CLAIMS PROCESSED OVER 30/45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
984*	100	96	96%

(*<1% of all paid and denied claims.)

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
122*	N/A	122	100%

(*<1% of all paid and denied claims.)

The Company was unable to provide the examiners with a list of claims that distinguished between those received electronically and those received by other means. Consequently, the examiners extracted the files to be used for timeliness studies based on the more liberal forty-five (45) day timeframe. The extraction of these files resulted in a population of 984 claims that had not been paid, denied or settled within forty-five (45) days. The Company was unable to provide the examiners with the original received date of many claims due to its method of renumbering (claim copying) claims upon reopening them for reprocessing and thus giving them a new received date. Since original received dates could only be found by opening each claim individually, the examiners were unable to pull an accurate population of claims for timeliness studies. Therefore the population of 984 appears to be less than the actual number of claims that exceeded forty-five (45) days. The examiners randomly selected a sample of 100 claims for review from the population of 984. After reviewing the details of these claims in the Company's system the examiners were able to determine that seventy-six (76) of these 100 claims were received electronically and that twenty-four (24) had been submitted by other means. These submission types were verified with the Company. The appropriate thirty (30) or forty-five (45) day timeframe was applied to each of these two types of claims during the examiners review.

It appears that the Company is not in compliance with Colorado law in that:

- Seventy-two (72) of the electronic claims in the sample appear to represent clean claims, but were not paid, denied, or settled within thirty (30) days; and

- Twenty-four (24) of the claims submitted by other means appear to represent clean claims, but were not paid, denied, or settled within forty-five (45) days

Additionally, using ACL™ software, the examiners reviewed the entire population of 476,764 claims provided by the Company. The examiners identified 122 claims that appear not to have been paid, denied, or settled within the ninety (90) days required by Colorado insurance law. Again due to the fact that the Company was unable to provide the examiners with the original received date of many claims due to its method of renumbering (claim copying) claims upon reopening them for reprocessing and thus giving them a new received date. Since original received dates could only be found by opening each claim individually, the examiners were unable to pull an accurate population of claims for timeliness studies, therefore the population of 122 appears to be less than the actual number of claims that exceeded ninety (90) days.

It appears that the Company is not in compliance with Colorado insurance law in that in at least 122 instances, the company failed to pay, deny or settle a claim within the required ninety (90) days. Absent fraud, all claims are to be paid, denied, or settled within ninety (90) days of receipt.

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all clean electronic claims are paid, denied, or settled within thirty (30) days; all clean non-electronic claims are paid, denied, or settled with forty-five (45) days; and except where fraud is involved, all claims are paid, denied, or settled within ninety (90) days as required by Colorado insurance law.

Issue J4: Failure, in some instances, to pay correct interest and or penalty on claims not paid, denied, or settled within the time frames required by law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states:

(4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5) (a) *A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.* [Emphasis added.]

(b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.* [Emphasis added.]

CLEAN CLAIMS OVER 30/45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
984*	100	63	63%

(<1% of all paid and denied claims.)

PAID CLAIMS OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
122*	N/A	95	78%

(<1% of all paid and denied claims.)

The Company was unable to provide the examiners with a list of claims that distinguished between those received electronically and those received by other means. Consequently, the examiners extracted the files to be used for timeliness studies based on the more liberal forty-five (45) day timeframe. The extraction of these files resulted in a population of 984 claims that had not been paid, denied or settled within forty-five (45) days. The examiners then randomly selected a sample of 100 claims for review. After reviewing the details of these claims in the Company's system the examiners were able to determine that seventy-six (76) of these 100 claims were received electronically and that twenty-four (24) had been submitted by other means. These submission types were verified with the Company. The appropriate thirty (30) or forty-five (45) day timeframe was applied to each of these two types of claims during the examiners review.

It appears that the Company is not in compliance with Colorado law in that of the fifty-two (52) claims submitted electronically that were not paid, denied, or settled within thirty (30) days where interest was determined to be due:

- Eleven (11) claims appeared to be clean claims, but no interest was paid; and
- Thirty-nine (39) claims appeared to be clean claims but the amount of interest paid was incorrect.

Also, it appears that the Company is not in compliance with Colorado law in that of the eighteen (18) claims submitted by other means that were not paid, denied, or settled within forty-five (45) days where interest was determined to be due:

- Four (4) claims appeared to be clean claims, but no interest was paid; and
- Nine (9) claims appeared to be clean claims but the amount of interest paid was incorrect.

Using ACL™ software, the examiners reviewed the entire population of 476,764 claims provided by the Company. The examiners identified 122 claims that appear not to have been paid or settled within the ninety (90) days required by Colorado insurance law. The Company was unable to provide the examiners with the original received date of many claims due to its method of renumbering (claim copying) claims upon reopening them for reprocessing. Since original received dates could only be found by opening each claim individually, the examiners were unable to pull an accurate population of claims for timeliness studies, therefore the population of 122 appears to be less than the actual number of claims that exceeded ninety (90) days.

Upon review of the 122 claims settled in over ninety (90) days, the examiners determined that a penalty payment was due in ninety-five (95) instances. It appears that the Company is not in compliance with Colorado insurance law in that the Company failed to pay a ten (10) percent penalty of the total amount ultimately allowed on the claim to the insured or health care provider on the ninety-first (91st) day on each of the ninety-five (95) claims not paid or settled within ninety (90) days.

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised it procedures to ensure that interest and/or penalties are paid for all claims not paid or settled within the time periods required by Colorado insurance law. The Company should work with the Division of Insurance to ensure that all past due interest and penalties are paid.

UTILIZATION REVIEW FINDINGS

Issue K1: Failure, in some instances, to include correct approval requirements in utilization review approval letters.

Section 10-16-704, C.R.S., Network Adequacy, states in part:

> (4) When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse. If a health carrier provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states:

> **Section 6. Procedures for Review Decisions**
>
> B. 1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the initial certification; and *shall provide written or electronic confirmation of the telephone notification* [emphasis added] to the covered person and/or the provider within two (2) working days of making the initial certification
>
> C. 2) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the certification; and *shall provide written or electronic confirmation* [emphasis added] to the covered person and/or the provider within one (1) working day after the telephone notification. The written or electronic notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.
>
> D. 1) In the case of a certification, the carrier *shall notify in writing* [emphasis added] the covered person and the provider rendering the service within five (5) working days of making the determination to provide coverage.

Furthermore, Colorado Division of Insurance Bulletin No. 10-00, Preauthorization for Treatments or Procedures by Managed Care Plans, issued July 17, 2000, states:

> **I. Background and Purpose**
>
> …Carriers often contract with a third party to perform medical necessity or utilization review. The results of these reviews are often provided to the insureds or their providers before the carrier has made its coverage determination. In an attempt to reserve the right to make a subsequent coverage determination, the initial notification sometimes contains disclaimer language stating that coverage is contingent upon a subsequent level of review.

After notification of approval at the initial review for medical necessity, some carriers are later denying coverage for the treatment or procedure which was the subject of the initial approval.

III. Division position

Colorado law states that once a carrier has "preauthorized" a treatment or procedure, the carrier cannot retrospectively deny the treatment or procedure, except for fraud and abuse, even where the benefit is not covered under the plan. See § 10-16-704(4), C.R.S. In addition, the statute prohibits the carrier from imposing a penalty on the insured for coverage of the benefit where the treatment or procedure was preauthorized. Covered persons and providers often do not distinguish between a medical necessity determination and a coverage determination, and act upon the initial medical necessity determination alone.

To avoid any confusion between the types of determination, the Division interprets this statute to mean that whenever a treatment or procedure is approved, irrespective of the terminology used by the carrier when reviewing the claim (e.g., precertification, preauthorization, prior authorization, medical necessity or utilization review), the carrier cannot subsequently deny coverage. In other words, *it is incumbent upon the carrier to make its coverage determination prior to the delivery of any medical necessity determination or other form of preauthorization to the covered person or their provider. The exceptions are for fraud and abuse, or where the insured loses coverage after the approval, but before actually obtaining the treatment or procedure.* [Emphasis added.] In addition, the carrier cannot reduce the benefit which was subject to the initial review in any manner, such as by requiring the insured to pay a higher co-pay than would normally be due under the plan.

Carriers cannot avoid the statutory requirement by including a disclaimer in the notice initially approving the treatment or procedure. For example, a carrier cannot notify a provider and/or insured that a particular treatment or procedure has passed a certain level of review, but final approval is contingent upon additional review. *To do so is a violation of the intent of the statute to prohibit retrospective denials after "preauthorization."* [Emphases added.]

APPROVED UR DECISIONS – WRITTEN CONFIRMATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,479	50	43	86%

The examiners reviewed a randomly selected sample of fifty (50) files from a summarized population of 2,479 Utilization Review Approvals made during the examination period of January 1, 2002 to December 31, 2002. It appears that in forty-three (43) instances the Company was not in compliance with Colorado insurance law in that the written confirmation provided to the provider and (or) covered person states that the claim may be retrospectively denied for reasons other than those provided for in Section 10-16-704(4) C.R.S. Two (2) of the three (3) letters referenced below are generated by National Imaging Associates, a

third party provider that handles radiology utilization review on behalf of Aetna. Please see excerpts below:

1. NIA form letter addressed to requesting provider (no document number available):

   "This *approval is subject to the member's eligibility and provider status* and is good for 90 days from the date of issue." [Emphasis added.]

   This letter was used in thirty-two (32) of the fifty (50) files reviewed.

2. NIA form letter addressed to covered person (no document number available):

   "In the case of Colorado residents, this certification decision does not guarantee coverage. Approval may be rescinded after the service has been provided in cases of fraud and abuse, misrepresentation, *exhaustion of benefits* or if the individual is no longer covered at the time the treatment or procedure is performed." [Emphasis added.]

   This letter was used in eleven (11) of the fifty (50) files reviewed.

3. Aetna form letter addressed to requesting provider (document number unreadable on faxed copy):

   "Validity of this authorization is subject to all those components being satisfied at the time the services are actually provided. This authorization is NOT effective if:

   1. *the member's health condition changes materially before the authorized services are provided, so that the authorized treatment/services are no longer medically necessary due solely to the member's materially changed health condition; OR*
   2. the member is no longer covered at the time the authorized treatment/services are actually performed; OR
   3. *the member has exceed any applicable benefit maximums under the plan; OR*
   4. *the selected procedures or services are excluded because of a preexisting condition; OR*
   5. the treatment/services certified in this letter can be denied in cases of fraud and abuse." [Emphases Added.]

   This letter goes on to state:

   "If the actual procedure differs from the information received, or the *circumstances change, we will review the claim when it is submitted.*" [Emphasis added.]

   Please note that the next to the last paragraph in this letter, <u>on its own</u>, appears to be in compliance with Colorado insurance law. This paragraph reads:

   "For Colorado residents: This certification decision does not guarantee coverage. The treatment or procedure certified can be denied in cases of fraud and abuse or if the individual is no longer covered at the time of the treatment or procedure."

   This letter was used in one (1) of the fifty (50) files reviewed.

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-704, C.R.S. and Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that approval letters sent to members and providers contain only those requirements for approval that are allowed by Colorado insurance law.

Issue K2: Failure, in some instances, to include all the required elements on utilization review denial notification letters.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states:

Section 6. Procedures for Review Decisions

E. A written notification of an adverse determination shall include the principal reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, including expedited appeals, *and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make that determination,* to any party who received notice of the adverse determination and who follows the procedures for a request. *A carrier shall specify that such an appeal process shall include a two-level internal review, except as provided for in section 8.I.A.5. of this regulation.*[Emphases added.]

UR DENIAL DECISIONS – WRITTEN NOTIFICATION - Internal Review Process

Population	Sample Size	Number of Exceptions	Percentage to Sample
453	47	11	23%

UR DENIAL DECISIONS – WRITTEN NOTIFICATION – Clinical Rationale Used

Population	Sample Size	Number of Exceptions	Percentage to Sample
453	47	3	6%

The examiners reviewed a randomly selected sample of forty-seven (47) files from a summarized population of 453 Utilization Review Denials made during the examination period of January 1, 2002 to December 31, 2002. It appears that in eleven (11) instances the Company is not in compliance with Colorado insurance law in that the written notice of adverse determination fails to specify that the appeal process includes a two-level internal review. All eleven (11) of the letters were generated by National Imaging Associates, a third party provider that handles radiology utilization review on behalf of Aetna. It also appears that in three (3) instances the Company is not in compliance with Colorado insurance law in that the written notice of adverse determination fails to include instructions for requesting a written statement of the clinical rationale and/or clinical review criteria used to make the determination.

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its utilization review denial procedures to ensure that written notification letters for adverse determinations include all the required elements as required by Colorado insurance law.

Issue K3: Failure, in some instances, to make prospective utilization review determinations within the time frame allowed by Colorado insurance law.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states:

> **Section 6. Procedures for Review Decisions**
>
> B. *For prospective review determinations*, a health carrier shall make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, referral, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required. In the case where a determination cannot be made because the carrier does not receive all information necessary to make the decision with the original request for treatment, the carrier shall request in writing, within two working days, the additional information needed. The carrier shall allow twenty (20) calendar days to receive the requested information. *Within two (2) working days of the due date or receipt date, whichever is earlier, the carrier shall make a determination based on the available information* and provide notification as specified in paragraphs (1) and (2) below. [Emphases added.]

UR DENIALS – Written Notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
453	47	5	11%

The examiners reviewed a randomly selected sample of forty-seven (47) files from a summarized population of 453 Utilization Review Denials made during the examination period of January 1, 2002 to December 31, 2002. Thirty-four (34) of these files were requests for prospective review. It appears that the Company is not in compliance with Colorado insurance law in that in five (5) of the thirty-four (34) prospective review files it took over two (2) working days for a determination to be made.

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that utilization review determinations are made within the time frame required to ensure compliance with Colorado insurance law.

Issue K4: Failure, in some instances, to provide telephone and/or written notification of adverse prospective utilization review denials within the time frames required by Colorado insurance law.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states:

Section 6. Procedures for Review Decisions

B. *For prospective review determinations*, [emphasis added] a health carrier shall make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, referral, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required. In the case where a determination cannot be made because the carrier does not receive all information necessary to make the decision with the original request for treatment, the carrier shall request in writing, within two working days, the additional information needed. The carrier shall allow twenty (20) calendar days to receive the requested information. Within two (2) working days of the due date or receipt date, whichever is earlier, the carrier shall make a determination based on the available information and provide notification as specified in paragraphs (1) and (2) below.

2. *In the case of an adverse determination, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination; and shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within one (1) working day of making the adverse determination.* [Emphasis added.]

UR DENIALS – Telephone notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
453	47	3	6%

The examiners reviewed a randomly selected sample of forty-seven (47) files from a summarized population of 453 Utilization Review Denials made during the examination period of January 1, 2002 to December 31, 2002. Thirty-four (34) of these files were requests for prospective review. It appears that the Company is not in compliance with Colorado insurance law in that in three (3) of the thirty-four (34) prospective review files telephone notification and/or written or electronic confirmation of the telephone notification was not made within the required timeframe.

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that telephone and/or written notice of adverse utilization review determinations is provided within the timeframe required by Colorado insurance law.

Issue K5: Failure, in some instances, to provide telephone notice of utilization review approvals within the time frame required by Colorado insurance law.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states:

Section 6. Procedures for Review Decisions

A. *For prospective review determinations*, [emphasis added] a health carrier shall make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, referral, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required. In the case where a determination cannot be made because the carrier does not receive all information necessary to make the decision with the original request for treatment, the carrier shall request in writing, within two working days, the additional information needed. The carrier shall allow twenty (20) calendar days to receive the requested information. Within two (2) working days of the due date or receipt date, whichever is earlier, the carrier shall make a determination based on the available information and provide notification as specified in paragraphs (1) and (2) below.

1. *In the case of a determination to certify an admission, referral, procedure or service, the carrier shall notify by telephone the provider rendering the service within one working day of making the initial certification;* [emphasis added] and shall provide written or electronic confirmation of the telephone notification to the covered person and or/provider within two (2) working days of making the initial certification.

UR APPROVALS – Telephone Notice

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,749	50	4	8%

The examiners reviewed a randomly selected sample of fifty (50) files from a summarized population of 2,479 Utilization Review Approvals made during the examination period of January 1, 2002 to December 31, 2002. Forty-three (43) of these files were requests for prospective review. It appears that the Company is not in compliance with Colorado insurance law in that in four (4) of the forty-three (43) prospective review files telephone notification was not made within the required timeframe.

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that telephone notice of utilization review approvals is provided within the time frame required by Colorado insurance law.

Issue K6: Failure, in some instances, to include a consultation with an appropriate clinical peer when evaluating first level appeals.

Section 10-16-113, C.R.S., Procedure for denial of benefits, states:

> (4) All written denials shall be signed by a licensed physician familiar with standards of care in Colorado.

Regulation 4-2-17(VIII), amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b), and 10-16-109, C.R.S., states:

> **I. Standard Appeals**
>
> A. First Level Appeal Review
>
> 2. *Appeals shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed.* [Emphasis added.] The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions.

LEVEL I APPEALS – Not Reviewed by Clinical Peer

Population	Sample Size	Number of Exceptions	Percentage to Sample
46	46	18	39%

The examiners reviewed the entire population of forty-six (46) Utilization Review first level appeals files requested during the examination period of January 1, 2002 to December 31, 2002. It appears that the Company is not in compliance with Colorado insurance law in that eighteen (18) of the first level appeals files did not include a consultation with an appropriate clinical peer by the physician reviewing the appeal.

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-113, C.R.S., and Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all first level appeals include a consultation with an appropriate clinical peer as required by Colorado insurance law.

Issue K7: Failure, in some instances, to provide written notification of first level appeal decisions within the time frames required by law. *(This was prior issue K1 in the findings of the 2000 final examination report.)*

Regulation 4-2-17(VIII), amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b), and 10-16-109, C.R.S., states:

I. Standard Appeals

A. First Level Appeal Review

3. For standard appeals *the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal.* [Emphasis added.]

LEVEL I APPEALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
46	46	16	35%

The examiners reviewed the entire population of forty-six (46) Utilization Review first level appeals files requested during the examination period of January 1, 2002 to December 31, 2002. It appears that the Company is not in compliance with Colorado insurance law in that in sixteen (16) instances the Company failed to notify the covered person and the physician of the appeal decision within twenty (20) working days of receiving the appeal request as required by Colorado law.

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all first level appeal written notifications are provided within the twenty (20) day time frame as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 1998 through December 31, 1998, the Company was cited for failure to provide the notification of decision on first level appeals within the required time frame. The violation resulted in Recommendation #49, that the Company implement appropriate changes to ensure that the notification of decisions involving first level appeals are sent within the time frame specified by law. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue K8: Failure to include all required elements in written notification letters sent to members and providers. *(This was prior issue K3 in the findings of the 2000 final examination report.)*

Regulation 4-2-17(VIII), amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b), and 10-16-109, C.R.S., states:

I. Standard Appeals

A. First Level Appeal Review

3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal. *The written decision shall contain* [emphasis added]:

a. The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For purposes of the section, the physician and the consulting clinical peers shall be called "the reviewers");

b. A statement of the reviewers' understanding of the reason for the covered person's request for an appeal;

c. The reviewers' decision in clear terms and the medical rational in sufficient details for the covered person to respond further to the health carrier's position;

d. A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria; and

e. A description of the process for submitting a grievance in writing requesting a further, second level appeal review of the case.

LEVEL I APPEALS – Written Notification Complete

Population	Sample Size	Number of Exceptions	Percentage to Sample
46	46	33	72%

The examiners reviewed the total population of forty-six (46) Utilization Review first level appeals files requested during the examination period of January 1, 2002 to December 31, 2002. It appears that the Company did not meet the requirements of Colorado insurance law in that in its written determination notices sent to the provider and the member do not contain all required elements.

- In thirty-three (33) of the files, the name, titles, and credentials of the providers involved were not listed on the written notifications;
- In one (1) of the files, the written notification did not clearly explain the decision and the medical rationale used;
- Eighteen (18) first level appeal written notification letters did not contain the clinical criteria used to make the decision and thirty-three (33) of the letters did not include instructions on how to request a copy of the documentation used to make the determination; and
- Eight (8) of the written notification letters in the first level appeal files did not contain a description of the process for submitting a request for a second level appeal and actually contained language prohibiting it.

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that level one written notification letters contain all necessary elements as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 1998 through December 31, 1998, the Company was cited for failure to include all of the information required by law in the notification of an adverse decision involving first level appeals. The violation resulted in Recommendation #51, that the Company implement appropriate changes to ensure that all notifications of adverse decision contain all of the information required by law to be provided to members. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue K9: Failure, in some instances, to schedule and hold a review meeting within forty-five (45) working days of receiving a request from a covered person for a second level review or failure to notify the covered person in writing at least fifteen (15) working days in advance of the review date.

Regulation 4-2-17(VIII), amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

B. Second Level Appeal Review

3. A health carrier's procedures for conducting a second level panel review shall include the following:

a. *The review panel shall schedule and hold a review meeting within forty-five (45) working days of receiving a request from a covered person for a second level review.* Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person including accommodation for disabilities. Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carriers expense, by conference call, video conferencing, or other appropriate technology. *The covered person shall be notified in writing at least fifteen (15) working days in advance of the review date.* [Emphases added.]…

LEVEL II APEALS – Review Meeting

Population	Sample Size	Number of Exceptions	Percentage to Sample
10	10	2	20%

LEVEL II APEALS – Prior Notification of Review Meeting

Population	Sample Size	Number of Exceptions	Percentage to Sample
10	10	3	30%

The examiners reviewed the entire population of ten (10) utilization review second level appeals files requested during the examination period of January 1, 2002 to December 31, 2002. It appears that the Company did not meet the requirements of Colorado insurance law in that it did not conduct review meetings or provide notice of the meeting within the time frames required by law.

- In two (2) cases the review meeting was not held within forty-five (45) days of the received date,

- In two (2) of the files, the covered person was not notified in writing of the meeting date at least fifteen (15) days prior to the scheduled date and in one (1) case no meeting was held.

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that review meetings are held within the forty-five (45) day time frame and that the covered person is notified of the meeting date at least fifteen (15) days prior to that date as required by Colorado insurance law.

Issue K10: Failure, in some instances, to include health care professionals with appropriate expertise in the second level review panels.

Regulation 4-2-17(VIII), amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

B. Second Level Appeal Review

2. *A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are health care professionals who have appropriate expertise* [emphasis added]. Such reviewing health care professionals shall meet the following criteria: not have been directly involved in the care previously; not be a member of the board of directors of the health plan; not have been involved in the review process for the covered person previously; and not have a direct financial interest in the case or the outcome of the review…

LEVEL II APEALS – Appropriate Professional Expertise

Population	Sample Size	Number of Exceptions	Percentage to Sample
10	10	3	30%

The examiners reviewed the entire population of ten (10) second level appeals for the examination period of January 1, 2002 to December 31, 2002. It appears that the Company is not in compliance with Colorado insurance law in that in three (3) of the ten (10) cases reviewed, the majority of members comprising the second level appeal panel did not appear to be health care professionals with appropriate expertise to review the issue being appealed. Additionally, in two (2) of the ten (10) cases the examiners were unable to determine whether the panel members had appropriate expertise since there was no documentation in the file indicating who participated in the panel.

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that health care professionals with appropriate expertise comprise a majority of the persons involved in second level panel review meetings as required by Colorado insurance law.

Issue K11: Failure, in some instances, to provide prior notification to members of the presence of Company attorneys at second level review meetings.

Regulation 4-2-17(VIII), amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

> B. Second Level Appeal Review
>
> 3. A health carrier's procedures for conducting a second level panel review shall include the following:
>
> e. If the health carrier desires to have an attorney present to represent the interests of the health carrier, it shall notify the covered person at least fifteen (15) working days in advance of the review that an attorney will be present and that the covered person may wish to obtain legal representation of his or her own…

LEVEL II APEALS – Notice of Attorney Presence at Hearing

Population	Sample Size	Number of Exceptions	Percentage to Sample
10	10	3	30%

The examiners reviewed the entire population of ten (10) utilization review second level appeals files requested during the examination period of January 1, 2002 to December 31, 2002. It appears that the Company did not meet the requirements of Colorado insurance law in that in three (3) cases it did not provide at least fifteen (15) working days notice to members when it was going to have an attorney present at the review meeting. Additionally, in two (2) cases the examiners were unable to determine if the member was given prior notification of the presence of an attorney due to lack of supporting documentation in the files.

Recommendation No. 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that covered persons are given prior notification of the presence of attorneys at review meetings as required by Colorado insurance law.

Issue K12: Failure, in some instances, to include all the required elements in written notifications of second level appeal determinations.

Regulation 4-2-17(VIII), amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

B. Second Level Appeal Review

3. A health carrier's procedures for conducting a second level panel review shall include the following:

g. The review panel, after private deliberation, shall issue a written decision to the covered person within five (5) working days of completing the review meeting. *The decision shall include:*

1. The names, titles, and qualifying credentials of the members of the review panel;
2. A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;
3. The rationale for the review panel's decision;
4. Reference to evidence or documentation considered by the review panel in making that decision;
5. In cases involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination, and additional appeal, review, arbitration or other options available to the covered person, if any; and
6. Effective June 1, 2000, notice of the covered person's right to request an independent external review. The notice shall comply with Section 5 of insurance Regulation 4-2-21. [Emphases added.]

LEVEL II APPEALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
10	10	6	60%

The examiners reviewed the entire population of ten (10) utilization review second level appeals files requested during the examination period of January 1, 2002 to December 31, 2002. It appears that the Company is not in compliance with Colorado insurance law in that six (6) of the ten (10) files did not include all the required elements in the written notification of the determination sent to the covered person.

Recommendation No. 25:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulations 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that written notification of second level appeal determinations contain all required elements to ensure compliance with Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

ISSUES	Rec. No.	Page No.
COMPANY OPERATIONS - MANAGEMENT		
A1: Failure, in some instances, to provide a complete response to examiners inquiries.	1.	18
A2: Failure, in some instances, to maintain records required for market conduct purposes. *(This was prior issue E23 in the findings of the 2000 final examination report.)*	2.	21
UNDERWRITING CONTRACT– FORMS		
E1: Failure to include the correct time frame for processing expedited appeals.	3.	24
E2: Failure to provide a complete and accurate description of the required Hospice Care benefits.	4.	26
E3: Failure to provide for continued coverage of a condition after a member has refused a recommended procedure or treatment.	5.	28
E4: Failure to include allowable amendments to large group plans only in the instances permitted by law.	6.	29
E5: Failure to include coverage for feeding appliances for newborns with cleft lip or cleft palate or both.	7.	32
E6: Failure to provide mandated coverage of therapies for treatment of congenital defects and birth abnormalities for covered children under five (5) years old.	8.	35
UNDERWRITING – CANCELLATIONS/NONRENEWALS/ DECLINATIONS		
H1: Failure, in some instances, to refund unearned premium in a prompt manner.	9.	37
CLAIMS		
J1: Failure, in some instances, to pay eligible charges or to request the additional information needed to properly adjudicate the claims.	10.	40
J2: Failure, in some instances, to process claims accurately.	11.	41
J3: Failure, in some instances, to pay, deny, or settle claims within the time frames required by law.	12.	43
J4: Failure, in some instances, to pay correct interest and or penalty on claims not paid, denied, or settled within the time frames required by law.	13.	46

UTILIZATION REVIEW		
K1: Failure, in some instances, to include correct approval requirements in utilization review approval letters.	14.	51
K2: Failure, in some instances, to include all the required elements on utilization review denial notification letters.	15.	52
K3: Failure, in some instances, to make prospective utilization review determinations within the time frame allowed by Colorado insurance law.	16.	53
K4: Failure, in some instances, to provide telephone and/or written notification of adverse prospective utilization review denials within the time frames required by Colorado insurance law.	17.	55
K5: Failure, in some instances, to provide telephone notice of utilization review approvals within the time frame required by Colorado insurance law.	18.	57
K6: Failure, in some instances, to include a consultation with an appropriate clinical peer when evaluating first level appeals.	19.	58
K7: Failure, in some instances, to provide written notification of first level appeal decisions within the time frames required by *law. (This was prior issue K1 in the findings of the 2000 final examination report.)*	20.	59
K8: Failure to include all required elements in written notification letters sent to members and providers. *(This was prior issue K3 in the findings of the 2000 final examination report.)*	21.	61
K9: Failure, in some instances, to schedule and hold a review meeting within forty-five (45) working days of receiving a request from a covered person for a second level review or failure to notify the covered person in writing at least fifteen (15) working days in advance of the review date.	22.	63
K10: Failure, in some instances, to include health care professionals with appropriate expertise in the second level review panels.	23.	64
K11: Failure, in some instances, to provide prior notification to members of the presence of Company attorneys at second level review meetings.	24.	65
K12: Failure, in some instances, to include all the required elements in written notifications of second level appeal determinations.	25.	67

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